

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED.  05/18/2011
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NAME OF PROVIDER OR SUPPLIER  BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure the care plan intervention and physician's orders for a therapy carrot were followed for 1 of 8 (Resident #14) sampled residents with range of motion (ROM) limitations.</p> <p>The findings included:</p> <p>Medical record review for Resident #14 documented an admission date of 4/12/00 with diagnoses of Status Post Cerebravascular Accident, Dysphagia and Senile Dementia. Review of a care plan dated 2/18/10 documented, "INCONTINENCE / PRESSURE ULCER... INTERVENTIONS... Carrot to left hand as tolerated." Review of a physician's order dated 4/29/11 documented, "...Therapy carrot to left hand as tolerated..."</p> <p>Observations in Resident #14's room on 5/16/11 at 12:23 PM and 5:52 PM and on 5/17/11 at 7:36 AM and 10:30 AM, revealed Resident #14 lying in bed without a carrot in his left hand.</p>	F 318	<p>F318</p> <p>A. On 5/18/11, at the point of discovery, the carrot device was placed in the resident's left hand by the licensed nurse on duty, also on 5/18/11, the PCM conducted education with the responsible CNT on the proper protocol for observing residents for placement of the ordered devices reflected on the Bedside Care Guide. (See Attachment 1) On 5/19/11, the Patient Care Manager (PCM) for the unit obtained a physician's order referring the resident to Occupational Therapy for re-evaluation of both extremities and to determine the need for the carrot device. The Occupational Therapist recommended and a physician's order was received for a palmer guard to the right hand and to continue with the carrot device to the left hand of the resident as previously ordered. (See Attachment 2) The resident's care plan and bedside care guide were updated with the new information on 5/19/11 by the Unit Assessment Coordinator. (See Attachment 3&amp;4)</p>	6/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Randee Morrison</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6-2-11</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that certain safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 318 SS=D	<p><b>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on medical record review, observation and interview, it was determined the facility failed to ensure the care plan intervention and physician's orders for a therapy carot were followed for 1 of 8 (Resident #14) sampled residents with range of motion (ROM) limitations.</p> <p>The findings included:</p> <p>Medical record review for Resident #14 documented an admission date of 4/12/00 with diagnoses of Status Post Cerebravascular Accident, Dysphagia and Senile Dementia. Review of a care plan dated 2/18/10 documented, "INCONTINENCE / PRESSURE ULCER... INTERVENTIONS... Carrot to left hand as tolerated." Review of a physician's order dated 4/29/11 documented, "...Therapy carot to left hand as tolerated..."</p> <p>Observations in Resident #14's room on 5/16/11 at 12:23 PM and 5:52 PM and on 5/17/11 at 7:36 AM and 10:30 AM, revealed Resident #14 lying in bed without a carot in his left hand.</p>	F 318	<p>B. To identify additional potentially affected residents an audit of residents with ordered hand devices will be conducted by the PCM, Charge Nurse, DON, ADON, Director of Wound and Skilled Services (DWSS), Nursing Supervisor, Resident Assessment Manager (RAM) or Unit Assessment Coordinator (UAC) to determine if residents have hand devices as ordered and that devices are on the Bed Side Care Guides. Some residents may be referred to the medical staff for re-evaluation and possible referral to OT for evaluation related to the need of a hand device or the appropriateness of a current hand device. Any changes to the plan of care will be noted in the resident care plan and on the bedside care guide by the PCM, Charge Nurse, RAM or UAC.</p> <p>C. The Range of Motion Policy; Care of the Contracted Hand Policy; the Interdisciplinary Identification and Management of Residents with Contractures Policy and the Change of Shift Report - Walking Rounds Policy will be reviewed and revised by the Director of Nursing or Assistant Director of Nursing. Training in services will be conducted with the CNTs and licensed nursing staff by the PCM, Charge Nurse, Nurse Educator, House Supervisor, DON, ADON, DWSS, RAM or UAC. Objectives will include:</p>	
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F 318 SS=D	<p><b>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on medical record review, observation and interview, it was determined the facility failed to ensure the care plan intervention and physician's orders for a therapy carot were followed for 1 of 8 (Resident #14) sampled residents with range of motion (ROM) limitations.</p> <p>The findings included:</p> <p>Medical record review for Resident #14 documented an admission date of 4/12/00 with diagnoses of Status Post Cerebravascular Accident, Dysphagia and Senile Dementia. Review of a care plan dated 2/18/10 documented, "INCONTINENCE / PRESSURE ULCER... INTERVENTIONS... Carrot to left hand as tolerated." Review of a physician's order dated 4/29/11 documented, "...Therapy carot to left hand as tolerated..."</p> <p>Observations in Resident #14's room on 5/16/11 at 12:23 PM and 5:52 PM and on 5/17/11 at 7:36 AM and 10:30 AM, revealed Resident #14 lying in bed without a carot in his left hand.</p>	F 318	<ul style="list-style-type: none"> <li>An understanding of the importance of timely and accurate identification of the residents with contractures to prevent or delay further decline</li> <li>Management of potential contractures</li> <li>Management of residents receiving devices and the ROM program</li> <li>Management and monitoring of positioning devices on the bedside care guide.</li> </ul> <p>Once weekly a member of the department leadership team will do rounds on at least 2 units and will do random checks of the bedside care guides to assure proper hand devices are in place.</p> <p>D. The PCM, Charge Nurse, Nursing Supervisor, DON, ADON, DWSS, Director of Quality or Quality Manager will audit 20% of the residents with anti-contraction hand devices for three months. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Director of Nursing.</p>	
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F 318	Continued From page 1 Observations in Resident #14's room on 5/18/11 at 8:10 AM, revealed Resident #14 seated in a geri-chair without a carrot in his left hand.  During an interview at B 4 nurses' station on 5/18/11 at 8:40 AM, Nurse #9 stated, "...It [therapy carrot] should be in the right hand..." Nurse #9 confirmed no therapy carrot was in place in either hand.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to monitor and ensure 1 of 4 (Resident #14) sampled residents fed by continuous Percutaneous Endoscopy Tube (PEG) received the appropriate formula and rate to maintain the resident's required nutritional needs.  The findings included:  Review of the facility's "...TF [Tube Feeding] Guidelines and Documentation..." policy documented, "...Tube fed residents will be	F 322	F322  A. On 5/16/11, at 5:45pm, the licensed nurse on duty hung the correct formula, Osmolite, at the correct rate, 74cc/hr. Also on 5/16/11 the PCM conducted education with the responsible licensed nursing staff on the unit regarding appropriately following the physician's orders with a review of Tube Feeding Guidelines and Documentation Policy also being done. (See Attachment 5)  B. To identify any additional residents with the potential to be affected an audit will be done of all tube fed residents by the PCM, Charge Nurse, House Supervisor, Quality Manager, dietitian, dietary tech, DON, ADON, DWSS, RAM or UAC to ensure the appropriate ordered formula and rate to maintain the resident's required nutrition needs is being provided to each resident. Any errors will be corrected as they are identified.	6/17/11

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F 322	<p>Continued From page 2</p> <p>routinely monitored to assure that nutritional goals are achieved. Dietician's routine review of residents on tube feeding should include: Visitation with the resident to note that the pump (if applicable) is infusing according to the tube feeding order..."</p> <p>Medical record review for Resident #14 documented an admission date of 4/12/00 with diagnoses of Status Post Cerebrovascular Accident, Dysphagia and Senile Dementia. Review of the physician's order dated 4/19/11 documented "...OSMOLITE 74ML [milliliters] / [per] HR [hour] TUBE X [times] 19 HOURS Each shift..."</p> <p>Observations in Resident #14's room on 5/16/11 at 5:52 PM, revealed Resident #14 was receiving a PEG tube formula of Two Calories High Nutrition (HN) at the rate of 50 ml/hr.</p> <p>During an interview in the Resident #14's room on 5/16/11 at 6:00 PM, Nurse #10 stated, "Order supposed to be Osmolite at 74 ml per hour."</p>	F 322	<p>C. The Tube Feeding Guidelines and Documentation Policy and the Change of Shift Report – Walking Rounds Policy will be reviewed and revised by the Director of Nursing or Director of Wound and Skilled Services. The nursing staff will be trained to check physician orders regarding tube feeding, the formula hanging and the rate on the pump during their walking rounds. A member of Department leadership during regular weekly rounds will check tube feeding rate for random residents on two units. Training regarding appropriate techniques to follow when changing / starting tube feeding will be conducted. Objectives will include :</p> <ul style="list-style-type: none"> <li>How to review the residents chart for the correct orders prior to implementing hanging of the formula;</li> <li>The policy and procedure for Tube Feeding Guidelines and Documentation</li> <li>The policy and procedure regarding Change of Shift Report – Walking Rounds</li> </ul> <p>Training will be done with the clinical nursing staff, dieticians and dietary techs. Training will be conducted by the Clinical Educator, PCM, Charge Nurse , House Supervisor, DON, ADON, DWSS, Quality Manager, RAM or UAC.</p>	
F 323 SS=0	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 323		

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F 322 Continued From page 2  
 routinely monitored to assure that nutritional goals are achieved. Dietician's routine review of residents on tube feeding should include: Visitation with the resident to note that the pump (if applicable) is infusing according to the tube feeding order..."  
 Medical record review for Resident #14 documented an admission date of 4/12/00 with diagnoses of Status Post Cerebrovascular Accident, Dysphagia and Senile Dementia. Review of the physician's order dated 4/19/11 documented "...OSMOLITE 74ML [milliliters] / [per] HR [hour] TUBE X [times] 19 HOURS Each shift..."  
 Observations in Resident #14's room on 5/16/11 at 5:52 PM, revealed Resident #14 was receiving a PEG tube formula of Two Calorie High Nutrition (HN) at the rate of 50 ml/hr.

F 322

D. The PCM, Charge Nurse, Quality Manager, Nursing Supervisor, will audit 20% of the residents with tube feeding orders to assure appropriate formula and rate of infusion is correct. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Director of Nursing.

F 323  
 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  
 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 323

A. For the resident affected, on 5/19/11 the PCM obtained an order for referral to Physical Therapy from the medical staff. Resident refused PT evaluation. (See Attachment 6) On 5/19/11 the bedside care guide was updated to include: Approach calmly, make eye contact and verbally reassure, supervise and intervene for safety as indicated, report refusals of care to the nurse. (See Attachment 7) On 5/19/11, the PCM completed education with the licensed nurses and CNTs on the unit addressing the new information on the bedside care guide. (See Attachment 8)

This REQUIREMENT is not met as evidenced by:

6/17/11

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F 323	<p>Continued From page 3</p> <p>Based on policy review, medical record review and interview, it was determined the facility failed to ensure that a resident at risk for falls had appropriate interventions implemented after a fall for 1 of 9 (Resident #26) sampled residents at risk for falls.</p> <p>The findings included:</p> <p>Review of the facility's "Falls and Restraints" policy documented, "...After a resident falls, a licensed nurse in charge of care must immediately put in place measurable interventions to prevent further accidents..."</p> <p>Medical record review for Resident #26 documented an admission date of 7/22/10 with diagnoses of Hypertension, Hypothyroidism, Osteoarthritis, Chronic Pain, Occipital Neuralgia and Depression. Review of the quarterly Minimum Data Set dated 4/3/11 documented "...resident is rarely/never understood... Memory problem..." Review of the care plan dated 8/3/10 and updated 5/14/11 documented "...PROBLEMS / STRENGTHS... Resident at risk of injury from falls R/T [related to]: Weakness, occ. [occasional] confusion, Refuses assist often... 5/14/11 Slid from W/C [wheelchair] while on toilet removing shoes... INTERVENTIONS... 5/14/11 Educate elder related to safety et [and] allowing staff to assist..." This was not an appropriate intervention for this resident's cognitive status.</p> <p>During an interview at R2 nurses' station on 5/18/11 at 1:08 PM, Nurse #11 was asked if she felt that educating Resident #26 was an appropriate intervention given her cognitive status. Nurse #11 stated, "... she likes to do</p>	F 323	<p>A comprehensive review of the chart was completed, with reassessment by the medical staff on 5/25/11. The reassessment indicates the resident has decision making ability noting the resident being "non-compliant, oriented to self, time and at times oriented to place." (See Attachment 9) The MDS dated 4/3/11 was reviewed and appropriately reflects this same information in section B0700 with a score of "0" = Understood and B0800 with a score of "0" = Understands. (See Attachment 10) The care plan was reviewed and modified to reflect the finding of the medical staff reassessment. (See Attachment 11) On 5/25/11 an MMSE was attempted by the Social Worker with the resident being non-compliant and declining to complete the MMSE. (See Attachment 12)</p> <p>B. To identify any additional residents that have the potential to be affected by this practice the PCM, Charge Nurse, DON, ADON, DWSS, Quality Manager, Nursing Supervisor, RAM or UAC will complete an audit of the residents that have had falls in the last 30 days and those who have cognitive impairments as indicated with a score of one "1" or more in the "B" section - B0700 and B0800 of their last MDS to determine if appropriate interventions have been implemented to provide optimal safety for these residents. Any deficiencies found will be corrected at the time they are found.</p> <p>C. The Falls and Restraint Policy and Occurrence Report Policy will be reviewed and revised by the DON or Director of Risk Management. The licensed clinical nursing staff will be educated by</p>	
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Continued From page 3  
 Based on policy review, medical record review and interview, it was determined the facility failed to ensure that a resident at risk for falls had appropriate interventions implemented after a fall for 1 of 9 (Resident #26) sampled residents at risk for falls.

The findings included:

Review of the facility's "Falls and Restraints" policy documented, "...After a resident falls, a licensed nurse in charge of care must immediately put in place measurable interventions to prevent further accidents..."

Medical record review for Resident #26 documented an admission date of 7/22/10 with diagnoses of Hypertension, Hypothyroidism, Osteoarthritis, Chronic Pain, Occipital Neuralgia and Depression. Review of the quarterly Minimum Data Set dated 4/3/11 documented "...resident is rarely/never understood... Memory problem..." Review of the care plan dated 8/3/10 and updated 5/14/11 documented "...PROBLEMS / STRENGTHS... Resident at risk of injury from falls R/T [related to]: Weakness, occ. [occasional] confusion, Refuses assist often... 5/14/11 Slid from W/C [wheelchair] while on toilet removing shoes... INTERVENTIONS... 5/14/11 Educate elder related to safety et [and] allowing staff to assist..." This was not an appropriate intervention for this resident's cognitive status.

During an interview at R2 nurses' station on 5/18/11 at 1:08 PM, Nurse #11 was asked if she felt that educating Resident #26 was an appropriate intervention given her cognitive status. Nurse #11 stated, "... she likes to do

F 323

the PCM, Charge Nurse, Clinical Educator, Nursing Supervisor, DON, ADON, DWSS, Quality Manager, RAM or UAC. Objectives will include:

- How to check the resident's chart if there is a question of decision making ability.
- Based on the resident's level of capacity a determination will be made as to the most appropriate type of intervention to implement to support the resident's safety.
- Guidelines for re-evaluation if the implemented intervention is not successful at increasing the safety level of the resident.

D. The PCM, Charge Nurse, Nursing Supervisor, DON, ADON, DWSS, Quality Manager, RAM or UAC will audit 20% of the residents with cognitive impairments and falls to assure that appropriate interventions have been initiated. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Director of Nursing

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<p>F 323</p> <p>F 325 SS=D</p>	<p>Continued From page 4 things her way..."</p> <p><b>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b></p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, it was determined the facility failed to implement new interventions to prevent additional weight loss for 1 of 8 (Resident #8) sampled residents with weight loss.</p> <p>The findings included:</p> <p>Medical record review for Resident #8 documented an admission date of 11/16/10 and a readmission date of 4/29/11 with diagnoses of Presenile Dementia, Seizure Disorder, Dysphagia and Anorexia. Review of Resident #8's monthly weights documented the following: 12/17/11 - 97.2 pounds (lb) and 1/11/11 - 92.2 lb. Review of the progress notes dated 1/20/11 documented Resident #8 was removed from the nutritional at risk program and weekly weights were discontinued.</p>	<p>F 323</p> <p>F 325</p>	<p>F325</p> <p>Based on medical record review and interview, it was determined the facility failed to implement new interventions to prevent additional weight loss for 1 of 8 (Resident #8) sampled residents with weight loss.</p> <p>Findings included:</p> <p>A. Prior to 1/20/11 multiple interventions were attempted including high calorie diet, altered diet, med wash. Conference held by interdisciplinary team with residents' family to discuss care goals. On 1/25/11 Appetite stimulant and Ensure Plus po bid ordered by Medical Staff. Family wanted to wait until weight is @ or below 80 lbs. before considering tube feeding. Family agreed to feed 2 meals daily since resident responds better to family. 3/3 Resident weight was 92.4 pounds. Family continues to feed meals 3/3 92.4# 100% Breakfast and supper - family feeding. Intake improved 3/31 Resident weight was stable at 95 lbs. Resident was assessed by Dietitian to determine if additional interventions were needed. Resident is currently on enteral feeding. Weight is being monitored weekly. Resident has gained 8 pounds since 1/20/11. No other interventions indicated at this time.</p>	<p>6/17/11</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
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NAME OF PROVIDER OR SUPPLIER  BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 323 F 325 SS=D	<p>Continued From page 4 things her way..."</p> <p><b>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b></p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to implement new interventions to prevent additional weight loss for 1 of 8 (Resident #8) sampled residents with weight loss.</p> <p>The findings included:</p> <p>Medical record review for Resident #8 documented an admission date of 11/16/10 and a readmission date of 4/29/11 with diagnoses of Presenile Dementia, Seizure Disorder, Dysphagia and Anorexia. Review of Resident #8's monthly weights documented the following: 12/17/11 - 97.2 pounds (lb) and 1/11/11 - 92.2 lb. Review of the progress notes dated 1/20/11 documented Resident #8 was removed from the nutritional at risk program and weekly weights were discontinued.</p>	F 323 F 325	<p>B. Director of Nutrition Services will identify residents with weight loss in the previous nine week, per 672 form from nursing and weight charts maintained by dietetic staff. Director of Nutrition and Dietitians will review charts to see if appropriate interventions are employed to improve nutritional status/weight. Further interventions will be employed immediately if indicated.</p> <p>C. Director of Nutrition Services will review NAR Policy and Weight Policy, make revisions as indicated. Director of Nutrition Services will in-service Dietitian and Dietitian Tech on NAR Policy and weight policy and appropriate interventions for weight loss. Objectives included:</p> <ul style="list-style-type: none"> <li>To insure staff is fully informed and understands the content of the NAR Policy and Weight Policy</li> <li>That appropriate assessments and interventions are established, and implemented for residents with weight loss or those placed in the NAR Program</li> </ul>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
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F 325	Continued From page 5  During an interview at the B4 nurses' station on 5/18/11 at 1:00 PM, Nurse #9 confirmed there were no new interventions implemented after the recorded weight loss on 1/11/11.	F 325	D. The Nutrition Service Director or the Director of Ancillary Services will audit 20% of residents with weight loss for three months to assure that appropriate interventions have been implemented. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the Director of Nutrition Service or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Nutrition Service Director or Dietitian.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure that oxygen (O2) was administered at the rate prescribed by the physician; O2 saturation levels were checked; the Minimum Data Set (MDS) was accurately completed; the care plan was revised and/or a physician's order was obtained for O2 for 3 of 10 (Residents #10, 20 and 22) sampled residents receiving oxygen.	F 328	F328  A. On 5/20/11 an order was obtained by the licensed nurse from the medical staff to discontinue obtaining the O2 saturation levels every shift on Resident #10 due to the resident having a chronic condition and being a hospice patient. The physician's order was also clarified to continue oxygen at 2L/min per NC PRN. (See Attachment 13) The resident's care plan was updated on 5/20/11 by the Unit Assessment Coordinator to reflect the appropriate interventions related to oxygen use. (See Attachment 14)	4/17/11

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F 328	<p>Continued From page 6</p> <p>The findings included:</p> <p>1. Medical record review for Resident #10 documented an admission date of 10/26/06 with diagnoses of Multiple Sclerosis, Paralysis, Hypertension, Chronic Renal Disease Stage III, Congestive Heart Failure and Coronary Artery Disease. Review of a physician's order dated 4/29/11 documented, "...O2 per NC [nasal cannula] @ [at] 2L/min [liters per minute]..."</p> <p>Observations in Resident #10's room on 5/16/11 at 10:35 AM and 3:55 PM, on 5/17/11 at 7:33 AM and 12:45 PM and on 5/18/11 at 8:30 AM, revealed Resident #10's O2 rate was set at 1.5 L/min.</p> <p>2. Medical record review for Resident #20 documented an admission date of 11/24/09 with diagnoses of Congestive Heart Failure, Adult Failure To Thrive, Hypertension and Bipolar. Review of a physician's order dated 3/25/11 documented, "...O2 @ 2 L/M to keep sats [saturation] above 92% [percent] as needed..." The facility was unable to provide documentation of Resident #20's O2 saturations. The MDS dated 4/24/11 was not coded for the use of O2. Review of the care plan dated 11/17/10 and updated 2/11 revealed no interventions for use of O2.</p> <p>Observations in Resident #20's room on 5/18/11 at 9:10 AM and 2:10 PM, revealed Resident #20 was receiving O2 per nasal cannula at 2 L/min.</p> <p>During an interview in the conference room on 5/18/11 at 2:15 PM, Resident Assessment Manager and Nurse # 12 confirmed that the O2</p>	F 328	<p>On 5/23/11 the oxygen flow rate was assessed and correctly adjusted to 2L/NC by the PCM to be in compliance with the physician's order. Education was completed by the Resident Assessment Manager with the Unit Assessment Coordinator on 5/18/11 on proper care plan revisions with order changes for residents receiving oxygen therapy. (See Attachment 15) The PCM on the unit conducted education with the nursing staff on appropriately monitoring the O2 use at the setting that is ordered by the physician on 5/26/11. (See Attachment 16) On 5/31/11 the Patient Care Manager received an oxygen saturation clarification order for Resident #20 from the medical staff to discontinue the oxygen saturation levels, but continue with O2@2L/min via NC. (See Attachment 17) The quarterly MDS dated 4/24/11 for Resident #20 was modified by the Resident Assessment Manager (RAM) for accurate MDS coding, section 001002C (O2 therapy) on 5/18/11. (See Attachment 18) On 5/18/11 the RAM updated the care plan for Resident #20 to reflect the appropriate interventions surrounding the use of oxygen and educated the Unit Assessment Coordinator on proper care plan revisions for residents receiving O2 therapy. (See Attachment</p>	

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NAME OF PROVIDER OR SUPPLIER  BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 328	<p>Continued From page 6</p> <p>The findings included:</p> <p>1. Medical record review for Resident #10 documented an admission date of 10/26/06 with diagnoses of Multiple Sclerosis, Paralysis, Hypertension, Chronic Renal Disease Stage III, Congestive Heart Failure and Coronary Artery Disease. Review of a physician's order dated 4/29/11 documented, "...O2 per NC [nasal cannula] @ [at] 2L/min [liters per minute]..."</p> <p>Observations in Resident #10's room on 5/16/11 at 10:35 AM and 3:55 PM, on 5/17/11 at 7:33 AM and 12:45 PM and on 5/18/11 at 8:30 AM, revealed Resident #10's O2 rate was set at 1.5 L/min.</p> <p>2. Medical record review for Resident #20 documented an admission date of 11/24/09 with diagnoses of Congestive Heart Failure, Adult Failure To Thrive, Hypertension and Bipolar. Review of a physician's order dated 3/25/11 documented, "...O2 @ 2 L/M to keep sats [saturation] above 92% [percent] as needed..." The facility was unable to provide documentation of Resident #20's O2 saturations. The MDS dated 4/24/11 was not coded for the use of O2. Review of the care plan dated 11/17/10 and updated 2/11 revealed no interventions for use of O2.</p> <p>Observations in Resident #20's room on 5/18/11 at 9:10 AM and 2:10 PM, revealed Resident #20 was receiving O2 per nasal cannula at 2 L/min.</p> <p>During an interview in the conference room on 5/18/11 at 2:15 PM, Resident Assessment Manager and Nurse # 12 confirmed that the O2</p>	F 328	<p>19) On 5/19/11 the PCM for the unit conducted an in-service on O2 Saturation and Placement of Oxygen with the licensed nurses. (See Attachment 20) On 5/18/11, a physician's order was obtained by the Charge Nurse for Resident #22 for O2NC@2L. On the same day the Resident Assessment Manager updated the resident's care plan with interventions addressing the oxygen use by the resident. (See Attachment 21) On 5/18/11, the PCM for the unit educated the Charge Nurse on the appropriate protocol for taking and recording a verbal order as well as entering the order into the E-MAR system. (See Attachment 22)</p> <p>B. To identify any additional residents that may be affected by this practice the PCM, Charge Nurse, DON, ADON, DWSS, RAM, Quality Manager, Nursing Supervisor or UAC will complete a comprehensive audit of the charts of those residents requiring the use of oxygen therapy to assure that the rate and O2 saturation levels are appropriately documented. The orders will be compared to what is showing on the flow meter as well as any saturations that should be documented. Any deficiencies that are found will be corrected at that time.</p>	

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NAME OF PROVIDER OR SUPPLIER  BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 328	<p>Continued From page 6</p> <p>The findings included:</p> <p>1. Medical record review for Resident #10 documented an admission date of 10/26/06 with diagnoses of Multiple Sclerosis, Paralysis, Hypertension, Chronic Renal Disease Stage III, Congestive Heart Failure and Coronary Artery Disease. Review of a physician's order dated 4/29/11 documented, "...O2 per NC [nasal cannula] @ [at] 2L/min [liters per minute]..."</p> <p>Observations in Resident #10's room on 5/16/11 at 10:35 AM and 3:55 PM, on 5/17/11 at 7:33 AM and 12:45 PM and on 5/18/11 at 6:30 AM, revealed Resident #10's O2 rate was set at 1.5 L/min.</p> <p>2. Medical record review for Resident #20 documented an admission date of 11/24/09 with diagnoses of Congestive Heart Failure, Adult Failure To Thrive, Hypertension and Bipolar. Review of a physician's order dated 3/25/11 documented, "...O2 @ 2 L/M to keep sats [saturation] above 92% [percent] as needed..." The facility was unable to provide documentation of Resident #20's O2 saturations. The MDS dated 4/24/11 was not coded for the use of O2. Review of the care plan dated 11/17/10 and updated 2/11 revealed no interventions for use of O2.</p> <p>Observations in Resident #20's room on 5/18/11 at 9:10 AM and 2:10 PM, revealed Resident #20 was receiving O2 per nasal cannula at 2 L/min.</p> <p>During an interview in the conference room on 5/18/11 at 2:15 PM, Resident Assessment Manager and Nurse # 12 confirmed that the O2</p>	F 328	<p>C. The Nasal Cannula Policy, the Change of Shift – Walking Rounds Policy and Transcription of Medical Orders Policy will be reviewed and revised by the DON, ADON or DWSS. Education will be provided by the PCM, Charge Nurse, Clinical Educator, Nursing Supervisor, DON, ADON, DWSS, Quality Manager, RAM or UAC for all licensed nursing personnel. Education objectives will include:</p> <ul style="list-style-type: none"> <li>• Procedures for monitoring and documenting oxygen saturations</li> <li>• Transcription of medical orders – oxygen and oxygen saturation orders</li> <li>• Updates on the care plan and bedside care guides.</li> <li>• Appropriate documentation on the MDS.</li> </ul> <p>D. The PCM, Charge Nurse or designee will audit 20% of the residents with oxygen and oxygen saturation orders for three months. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Director of Nursing.</p>	
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F 328	Continued From page 7 sats had not been checked, the MDS was not accurately completed and the care plan was not revised.  3. Medical record review for Resident #22 documented an admission date of 1/4/08 and a readmission date of 5/9/11 with diagnoses of Dementia, Hypertension, Schizophrenia and Bipolar. Review of the physician's orders dated 4/28/11 did not include no order for oxygen.  Observations in Resident #22's room on 5/16/11 at 12:00 PM and on 5/18/11 at 2:00 PM, revealed Resident #22 receiving O2 at 2L/min per NC.  During an interview at the B4 nurses' station on 5/18/11 at 2:00 PM, Nurse #9 confirmed there was no physician's order for O2 for Resident #22.	F 328	F332  A. Resident #8 – On 5/19/11 the licensed nursing staff was educated by the PCM regarding procedures for preparing liquid medications when odd dosages are ordered. Topics covered included the use of specialized caps for the liquid bottles and syringes to draw up the liquid medication to obtain the most accurate measurement. (See Attachment 23) On 5/18/11 a cap was placed on the liquid Phenytoin bottle by the PCM for use with the syringe for accurate measurement. Resident #1 – On 5/16/11 and 6/1/11 the PCM educated the responsible nurse on the protocol for the proper administration of crushed medications via PEG tube. Formal education with the nursing staff took place on 5/25/11 covering the protocol for the proper administration of crushed medications via PEG tube. Emphasis was placed on administering the medication in its entirety with no residue to be left in the medication cups. (See Attachment 24) Resident #3 – On 5/19/11 in-service was held by the PCM with the licensed nurses and on 5/26/11 the PCM educated the responsible nurse on the appropriate guidelines for the administration of insulin in conjunction with meal times and snack delivery if meals are delayed. (See Attachment 25) Resident #2 – On 5/19/11 the PCM in-serviced the licensed nurse and on 5/26/11 the PCM educated the responsible nurse on the proper procedure to follow when administering oral inhalants. (See Attachment 26)	6/17/11
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on review of the "Medication Guide for the Long-Term Care Nurse", policy review, medical record review, observation and interview, it was determined the facility failed to ensure 4 of 18 (Nurses #1, 2, 3 and 4) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 4 errors were observed out of 43 opportunities for error, resulting in a medication error rate of 9.01%.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
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F 332	<p>Continued From page 8                      The findings included:</p> <p>1. Review of the facility's "ADMINISTERING MEDICATIONS VIA GASTROSTOMY TUBE" policy documented, "...5. Verify the medications with the eMAR [electronic Medication Administration Record]. 6. Crush pill and/or empty capsules if appropriate. 7. Liquid medications-use dosing cup or syringe to measure... 12. Mix medications with water and administer through tube..."</p> <p>a. Medical Record review for Resident #8 documented an admission date of 11/16/10 with diagnoses of Decubitus Ulcer Dorsal Left Foot, Decubitus Ulcer Sage IV, Decubitus Ulcer Right Ankle Stage III and Decubitus Ulcer Left Heel. Review of a physician's order dated 4/29/11 documented, "Phenytoin 300 mg [milligrams] 12 ml [milliliters] PT [per tube] BID [two times a day]..."</p> <p>Observations in Resident #8's room on 5/17/11 at 7:37 AM, revealed Nurse #3 poured Phenytoin suspension into a plastic medication cup and administered the Phenytoin suspension to Resident #8. Nurse #3 did not use a syringe to measure the dosage. Failure to use a syringe to measure the accurate dosage resulted in medication error #1.</p> <p>During an interview at the B4 nurses' station on 5/17/11 at 12:40 PM, Nurse 33 was asked about Resident #8's dosage of Phenytoin. Nurse #3 stated, "I poured it at eye level just a little bit above the ten."</p> <p>During an interview in the conference room on</p>	F 332	<p>B. To identify any additional residents with the potential to be affected the PCM, Charge Nurse, DON, ADON, DWSS, Nurse Educator, Clinical Pharmacist, RAM or UAC will complete a Med Pass review with the regularly scheduled licensed nurses over the next two weeks for residents that</p> <p>receive crushed medications by PEG tube, those receiving Novolog insulin, those receiving oral inhalants and those receiving liquid phenytoin. The nurse's medication administration technique will be monitored and any deficiencies noted during the licensed nurse's medication administration will be addressed at that time by the reviewer.</p> <p>C. The Administration of Medication Policy, Protocol: Hyperglycemia Policy and Oral Inhalation Administration Policy will be reviewed and updated as indicated by the DON and the Clinical Pharmacist. Education will be provided to Wound Nurses by the PCM, Charge Nurse, Nurse Educator, Nursing Supervisor, DON, ADON, DWSS, RAM, Quality Manager or UAC, regarding any policy additions or changes. Objectives will include:</p>	

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NAME OF PROVIDER OR SUPPLIER  BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 332	<p>Continued From page 9</p> <p>5/18/11 at 10:00 AM, the Director of Nursing (DON) stated, "If dosage not on cup they need to use a syringe to measure the dose."</p> <p>b. Medical record review for Random Resident (RR) #1 documented an admission date of 12/27/07 with diagnoses of Adult Failure To Thrive, Status Post Cerebrovascular Accident with Dysphagia and Seizure Disorder. Review of a physician's order dated 4/1/11 documented, "...Start Gabapentin 800mg QID [four times a day]..."</p> <p>Observations in RR #1's room on 5/16/11 at 11:45 AM, Nurse #1 administered Gabapentin 800 mg to RR #1 per Percutaneous Endoscopy Gastrostomy tube. Nurse #1 left a large amount of the crushed medication in the medication cup. Failure to administer the complete dosage of the medication resulted in medication error #2.</p> <p>During an interview at B3 nurses' station on 5/17/11 at 4:10 PM, Nurse #1 stated, "I need to make sure I get all the medication."</p> <p>During an interview in the conference room on 5/18/11 at 10:00 AM, the DON stated, "They need to make sure the cup is empty, give all the med [medication]..."</p> <p>2. Review of the facility's "Expected snack or meal delivery in conjunction with routine insulin or SSI [Sliding Scale Insulin] delivery" policy documented, "Novolog; Snack or meal within 10-[to] 20 minutes of delivery..."</p> <p>Medical record review for RR #3 documented an admission date of 2/28/11 with diagnoses of</p>	F 332	<ul style="list-style-type: none"> <li>• Use of the specialized caps for the liquid medication bottles.</li> <li>• Use of the syringes to draw up dosages with unusual increments.</li> <li>• Appropriate methods for crushing, mixing and administering medications via the PEG tube</li> <li>• Protocols surrounding administration of Novolog insulin – serve a meal or snack within 10 -20 minutes of giving the insulin, include documentation of intake</li> <li>• Appropriate steps to take when administering an oral inhalant when the resident receives multiple puffs of the same medication.</li> </ul> <p>D. The PCM, Charge Nurse or designee will conduct a random audit of 20% of the licensed nurses during their routine medication pass for three months. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Director of Nursing.</p>	
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NAME OF PROVIDER OR SUPPLIER  BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	<p>Continued From page 10</p> <p>Chronic Respiratory Failure, Obstructive Sleep Apnea, Hypertension and Diabetes Mellitus. Review of a physician's order dated 4/29/11 documented, "...IF BS [blood sugar] &gt; [greater than] 180 SLIDING SCALE NOVOLOG INSULIN AS INDICATED &amp; [and] DOCUMENT. 180-250... 2U [units] OF NOVOLOG INSULIN..."</p> <p>Observations in RR #3's room on 5/16/11 at 4:23 PM, revealed Nurse #2 administered Novolog insulin 2U to RR #3. RR #3 did not receive her meal tray until after 6:00 PM. The administration of the Novolog insulin more than an hour and thirty-seven minutes before supper was served resulted in medication error #3.</p> <p>During an interview in the conference room on 5/18/11 at 10:00 AM, the DON was asked about insulin administration and and mealtimes. The DON stated, "With Novolog should have a snack or meal within 10 to 20 minutes..."</p> <p>3. Review of the "Medication Guide for the Long-Term Care Nurse", page 75, documented, "...Wait one minute between "puffs" for multiple inhalations of the same drug..."</p> <p>Medical record review for RR #2 documented an admission date of 5/9/11 with diagnoses of Cerebrovascular Disease, Congestive Heart Failure and Dysphagia. Review of a physician's order dated 5/16/11 documented, "...Albuterol Inhaler ii [two] puffs BID..."</p> <p>Observations in RR #2's room on 5/18/11 at 9:07 AM, Nurse #4 administered two puffs of an Albuterol inhaler to RR #2 without pausing between puffs. Nurse #4 did not pause at least</p>	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
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F 332	Continued From page 11 one minute between the puffs. Failure to wait at least one minute between puffs resulted in medication error #4.	F 332		6/17/11
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 1 of 18 nurses (Nurse #2) administered medications without a significant error. Nurse #2 failed to administer insulin within the proper time frame related to meals for Random Resident (RR) #3.  The findings included:  Review of the facility's "Expected snack or meal delivery in conjunction with routine insulin or SS) [Sliding Scale Insulin] delivery" policy documented, "Novolog: Snack or meal within 10-[to] 20 minutes of delivery..."  Medical record review for RR #3 documented an admission date of 2/28/11 with diagnoses of Chronic Respiratory Failure, Obstructive Sleep Apnea, Hypertension and Diabetes Mellitus. Review of a physician's order dated 4/29/11	F 333	F333  A. Resident #3 - On 5/17/11 the PCM counseled the nurse involved with formal written education being done on 5/26/11 on the appropriate guidelines for conducting accuchecks as ordered by the physician and the administration of insulin in conjunction with meal times and/or snack delivery if meals are delayed. (See Attachment 25)  B. To identify any additional residents with the potential to be affected the PCM, Charge Nurse, DON, ADON, DWSS, Nurse Educator, Clinical Pharmacist, RAM or UAC will complete a Med Pass for nurses over the next two weeks that are administering medications to residents that are receiving Novolog insulin. The nurse's medication administration technique will be monitored and any deficiencies noted will be addressed at that time.  C. The Administration of Medication Policy and the Protocol: Hyperglycemia Policy will be reviewed and revised by the Director of Nursing or Assistant Director of Nursing. Education will be provided by the PCM, Charge Nurse, Nurse Educator, House Supervisor, DON, ADON, DWSS, RAM or UAC regarding any policy additions or changes. Objectives to include:	6/17/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
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F 333	<p>Continued From page 12 documented, "...IF BS [blood sugar] &gt; [greater than] 180 SLIDING SCALE NOVLOG INSULIN AS INDICATED &amp; [and] DOCUMENT. 180-250... 2U [units] OF NOVLOG INSULIN..."</p> <p>Observations in RR #3's room on 5/16/11 at 4:23 PM, Nurse #2 administered Novolog insulin 2U to RR #3. RR #3 did not receive her meal tray until after 6:00 PM. The administration of the Novolog insulin more than an hour and thirty-seven minutes before supper was served resulted in a significant medication error.</p>	F 333	<ul style="list-style-type: none"> <li>• Variances in onset times of Novolog as compared to other insulin's (Humalog, Novolin, Humulin)</li> <li>• Protocols surrounding appropriate administration of Novolog insulin</li> <li>• Delivery of a meal or snack within 10 -20 minutes of administering the Novolog insulin. Importance of documentation of intake when insulin has been administered</li> <li>• Monitor for signs and symptoms of Hypoglycemia after the administration of the Novolog</li> </ul> <p>D. The PCM, Charge Nurse or designee will audit 20% of the residents with Novolog insulin administration orders for three months. Audits will assess the times Novolog was delivered as well as the gap between insulin administration and meal/snack delivery time. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Director of Nursing.</p>	